TESTIMONY PRESENTED TO THE APPROPRIATIONS COMMITTEE
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Testimony Supporting Senate Bill No. 22

AN ACT CONCERNING THE PREVENTION OF FRAUD IN GOVERNMENT PROGRAMS

Good afternoon, Senator Bye, Representative Walker and distinguished members of the Appropriations Committee. Thank you for the opportunity to offer testimony in support of Senate Bill No. 22, An Act Concerning the Prevention of Fraud in Government Programs.

This Governor's bill will help to ensure that laws are in place to combat fraud directed against state programs and maximize savings and recovery targets as required under the FY 2015 enacted budget, which assumes a $39 million increase in recoveries (from $65 million to $104 million) as a result of enhanced efforts to reduce fraud, waste and abuse.

Connecticut's False Claims Act (FCA) authorizes the Office of the Attorney General (OAG) to initiate investigations and prosecute false claims submitted under a medical assistance program administered by the Department of Social Services (DSS). In addition, the FCA provides for a private party to initiate an FCA case and gives the OAG the ability to intervene in that action and take primary responsibility for the conduct of the litigation. If a case is initiated by a private party under the FCA and there is a court award or an out-of-court settlement, the court can award the private party between 15% to 30% of the state's recovery, as well as reasonable expenses and attorney's fees and costs against the defendant which the court finds have been necessarily incurred. Eligibility for the award and/or the amount of the award may vary based on case specific considerations and the orders of the court. The FCA also provides protection and remedies to whistleblowers from workplace retaliation.

The FCA authorizes the following remedies:

- Civil penalties of $5,500 to $11,000 per violation, with certain upwards adjustments;
- Treble damages – recovery of three times the amount of damages sustained by the state;
- Costs of investigation and prosecution of the false claims violation.

The FCA delineates very specific procedures for the conduct of any litigation as well as the standard of proof to prove a violation and damage under the False Claims Act. A person does not violate the FCA simply by submitting a false claim to the government—to establish a violation of the FCA the state must prove a person submitted, or caused the submission of, the false claim *with knowledge of the falsehood.* In other words, innocent billing mistakes do not fall within the scope of the statute. Moreover, these cases cannot be frivolous. If all elements of the cause of action are met, then examples of conduct that could constitute a false claim include:

- Billing for services not rendered,
- Providing unnecessary services,
- Billing for non-covered services as covered services,
- Billing for more expensive services than those that are necessary (upcoding),
- Billing separately for services that should be bundled together at a lower rate,
- Duplicate billing,
- Altering a claim or a document to support a claim (e.g., a certificate of medical necessity),
- Falsifying cost reports,
- Billing for brand-name drugs when generic drugs are dispensed, or
- Off-label marketing of drugs or medical devices.

Currently, the state's False Claims Act language is codified under sections 17b-301a through 17b-301p of the general statutes, and is limited to the medical assistance programs administered by DSS. This bill extends the application of Connecticut's False Claims Act to all health and human services agencies and programs, as well as state payments made for state employee and retiree health and state paid Workers' Compensation medical claims. Of the 31 states with False Claims Acts, 29 allow individuals to prosecute an action on the state's behalf. Of these 29 states, only 10 states – including Connecticut – limit recovery to false claims related to the Medicaid program.

In November 2013, a vendor was secured to create and implement a state-of-the-art fraud detection system that will apply sophisticated analytic and data mining tools to selected state data sources in order to identify possible patterns of fraud, waste and abuse perpetrated against state programs such as Medicaid and provide leads for investigative follow-up and future criminal, civil or administrative action. In conjunction with this activity, this bill expands the False Claims Act to make it consistent with the scope of work included in the new fraud contract.

The enacted budget includes new staff in both the OAG and the Medicaid Fraud Control Unit in the Office of the Chief State's Attorney to assist with fraud recovery efforts. In addition, the Governor is recommending a $200,000 adjustment in the OAG's budget to support litigation expenses for the increased

caseload resulting from these efforts, as well as annualized funding for additional staff for the Office of Quality Assurance in DSS to pursue leads generated through the initiative.

This initiative will assist the state in realizing the $104 million in savings in the FY 2015 enacted budget. More importantly, it will help to ensure that the state's limited resources are available for the purposes for which they were intended, and will help ensure the integrity of state programs.

I would again like to thank the committee for the opportunity to present this testimony. I respectfully request that the committee take favorable action on the Governor's bill and I would be happy to answer any questions you may have.